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ABSTRACT

This paper describes the development of the National Skill Standards for Community Based Human Service Practitioners and reports on a survey of states' training and certification requirements. The standards are grouped into 12 broad competency areas: (1) participant empowerment; (2) communication; (3) assessment; (4) community and service networking; (5) facilitation of services; (6) community living and supports; (7) education, training, and self-development; (8) advocacy; (9) vocational, educational, and career support; (10) crisis intervention; (11) organizational participation; and (12) documentation. The survey of 32 states examined their training and certification requirements for direct service workers supporting people with developmental disabilities in residential settings and compared the findings with competencies identified in the National Skill Standards for Community Based Human Service Practitioners. Although almost all of the states surveyed did mandate some type of training for residential direct service workers, only nine states had a certification process for direct service workers. A table of the certification and training requirements in the 32 states is provided. Training programs are urged to: require demonstrated competence; verify the type of training; incorporate validated standards; allow workers to demonstrate competency; create a common language; consider unique requirements of individual states; and give college credit. (CR)

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Policy Research Brief

CENTER ON RESIDENTIAL SERVICES AND COMMUNITY LIVING
UNIVERSITY OF MINNESOTA

National Voluntary Credentialing for Direct Service Workers

This Policy Research Brief summarizes the results of a study conducted at the Research and Training Center on Residential Services and Community Living, Institute on Community Integration, University of Minnesota, in 1995. Authors of this issue are Amy Hewitt, Sheryl A. Larson, and Susan O'Nell. The research was funded by grants #H133B30072 and #H133050037 from the National Institute on Disability and Rehabilitation Research (NIDRR), U.S. Department of Education; and grant #90DD0302 from the Administration on Developmental Disabilities, U.S. Department of Health and Human Services.

■ Introduction

Training for persons providing direct supports is an important component of quality services to people with developmental disabilities. Regardless of agency philosophy, administrative intentions, or types of service environments, if direct service workers do not have the necessary knowledge, skills, and attitudes to provide support services, the quality of life for the people receiving services is diminished. Adequate training and education programs are often unavailable to direct service workers. Those that do exist often have not fully equipped workers with the skills needed to support a variety of consumers who receive services in different types of settings. Characteristics of adequate training include the following: (1) the topics must be relevant to the job, (2) the materials used and instructor knowledge must be current, (3) the delivery of training must be in a form that increases participants' ability to retain information (e.g., use of multiple modes of instruction), and (4) the training must be competency-based to ensure that the learner has acquired the actual skills necessary to perform required job duties. The inadequate preparation of employees and the related lack of information about what to expect in a job are significant factors influencing high turnover rates, averaging 57–71% (Premack & Wanous, 1985; Zaharia & Baumeister, 1981), which have plagued the field of developmental disabilities for many years (Braddock & Mitchell, 1992).

Several national efforts have been initiated in recent years to define topics, training methods and testing procedures useful in developing high quality training. Among these efforts are training needs assessment studies (Hewitt & Larson, 1993) and the Community Support Skill Standards Project (HSRI, 1995). The Community Support Skill Standards Project was funded by the U.S. Department of Education to develop validated national skill standards for community based human service practitioners. The broad goals of the project were to bridge the gap between industry and education by creating industry-wide skill standards and certification procedures that meet the needs of employers within the human service industry, and increase both horizontal and vertical career opportunities for direct service workers (Taylor, Bradley, & Warren, 1993).

The first step in developing the national skill standards was to complete a comprehensive job analysis using a modified "developing a curriculum methodology" (DACUM) in workshops with participants from a variety of entry level human service jobs. The worker sample for these workshops was drawn to ensure diversity of race, gender, types of individuals served, and community context (urban, rural or suburban). The results of the DACUM analyses were then validated by industry experts in a final job analysis workshop.

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Once the job analysis was complete, these results along with a number of guiding principles designed to be responsive to current and future best practices (e.g., stimulate aspiration to high levels of worker performance and quality, anticipate major trends and shifts in the field of human services, enhance recognition of cultural diversity, and embrace the vision of the consumer of human services as an active participant in directing all aspects of his or her supports), were used by industry experts to design the skill standards (HSRI, 1995). The final steps in this development process included having the draft standards validated by key industry stakeholders and integrating their suggestions into the final standards.

One outcome of this project was the creation of the National Skill Standards for Community Based Human Service Practitioners. These standards are integrated into 12 broad competency areas for community based human service practitioners, which are described in Table 1.

Table 1: National Skill Standards Competency Areas

1 **Participant Empowerment.** The competent Community Based Human Service Practitioner (CBHSP) enhances the ability of the participant to lead a self-determining life by providing support and information to build self-esteem and assertiveness and to make decisions. Topics: self-determination; empowerment; consumer-driven services; self-advocacy; human, legal and civil rights; decision making.

2 **Communication.** The CBHSP should be knowledgeable about the range of effective communication and basic counseling strategies and skills necessary to establish a collaborative relationship with the participant. Topics: communication skills; augmentative and alternative communication; acronyms and terms used within the field; basic supportive counseling skills.

3 **Assessment.** The CBHSP should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires, and interests of participants. Topics: assessment strategies and processes; conducting assessments; identifying preferences, capabilities, and needs of participants; using assessment tools; disseminating findings to the participant.

4 **Community and Service Networking.** The CBHSP should be knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports. Topics: making community connections; building support networks; identifying available community resources; outreach.

5 **Facilitation of Services.** The CBHSP is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner. Topics: collaborative relationships; ethical standards of practice; individualized plans; strategies to achieve participant outcomes; developing successful program plans.

6 **Community Living and Supports.** The CBHSP has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships. Topics: human development; sexuality; health; grooming; toileting; personal management; household management; nutrition and meal planning; laundry; transportation; adaptive equipment; physical, occupational and communication therapy intervention; development of friendships and socialization; consumer-driven recruitment; training of service providers.

7 **Education, Training, and Self-Development.** The CBHSP should be able to identify areas for self-improvement, pursue necessary educational / training resources, and share knowledge with others. Topics: completing required / mandated training; professional development; community outreach.

8 **Advocacy.** The CBHSP should be knowledgeable about the diverse challenges facing participants (e.g., human rights, legal rights, administrative and financial issues) and should be able to identify and use effective advocacy strategies to overcome such challenges. Topics: identifying advocacy issues, laws, services, and community resources for people with disabilities; barriers to service delivery; negotiation.

9 **Vocational, Educational, and Career Support.** The CBHSP should be knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals. Topics: vocational assessment; opportunities for career growth and advancement; marketing skills; environmental adaptations; job interviewing; job retention; vocational services.

10 **Crisis Intervention.** The CBHSP should be knowledgeable about crisis intervention and resolution techniques and should match such techniques to particular circumstances and individuals. Topics: crisis intervention strategies; conflict resolution; de-escalation; environmental adaptations.

11 **Organizational Participation.** The CBHSP is familiar with the mission and practices of the support organization and participates in the life of the organization. Topics: program evaluation; organizational structure and design; cultural sensitivity; peer support; organizational development / budgetary issues.

12 **Documentation.** The CBHSP is aware of the requirements for documentation in their organization and is able to manage the requirements efficiently. Topics: data collection and analysis; confidentiality; ethical practice; documentation strategies.

Recently a proposal for national voluntary credentialing was presented by a collaborative task force of industry stakeholders including the American Association on Mental Retardation, American Network of Community Options and Resources, President's Committee on Mental Retardation, Reaching Up, American Association of University Affiliated Programs, and Self-Advocates Becoming Empowered. This proposal recommended that direct service workers have the opportunity to secure a national credential by:

- Having at least 18 months of community based experience as a direct service worker;
- Meeting any statewide direct service worker training or certification requirements;
- Completing at least twelve credits of specialized course work in the disability field from an accredited institution of higher education or completing an equivalent number of hours of approved continuing education or inservice training that award continuing education units;
- Demonstrating the competencies addressed within the National Skill Standards for Community Based Human Service Practitioners; and
- Demonstrating consumer satisfaction with direct service worker services.

The goals of this proposal were to resolve many critical problems which plague the industry and to enhance the professional status of direct service workers. Specific objectives of the proposed voluntary credential include: (1) reducing turnover, (2) improving direct service worker job skills, (3) improving direct service worker access to inservice, continuing and higher education, (4) creating portable career pathways that are recognized across agencies and states, (5) providing a basis and rationale for salary increments for certified workers, (6) increasing the availability of trained and well-qualified direct service workers, (7) improving the quality of services to children and adults with disabilities who are living in the community, and (8) improving the professional status and public image of direct service workers (Ebenstein, 1995).

Credentialing is one way to recognize direct service workers who have the attitudes, training, experience, and competencies needed to do their jobs. A portable, nationwide, standardized certification could increase the flexibility of direct service workers in moving from one state, agency or service type to the next, and could save training dollars that sometimes go to retraining workers in skills they have already learned elsewhere. If critical core competencies are identified, accepted and required for certification, states might have a foundation for ensuring that all direct service workers have the quantity and quality of training needed in the various types of settings where people with developmental disabilities are receiving supports.

■ Purpose and Methods of the Study

In 1995, the Research and Training Center on Residential Services and Community Living conducted a survey of 32 states concerning training and certification requirements for direct service workers supporting people with developmental disabilities in residential settings. The study compared data across states and setting types, and then compared the results to competencies identified in the National Skill Standards for Community Based Human Service Practitioners. The information was used to identify important considerations regarding the development of a national voluntary credentialing system for direct service workers.

The complexity of the many agencies and requirements in each state regarding direct service worker training led the focus of this effort to be on residential services only. Contacts within the states included state directors of developmental disability services and special education; staff from governor's councils on disabilities; outreach trainers and other people knowledgeable about training at state University Affiliated Programs (UAPs); protection and advocacy groups; and service providers. When applicable, copies of the actual regulations which commented on training were requested and reviewed.

The survey gathered information to answer the following questions:

- Did the state require certification or mandatory training for direct service workers and what were the requirements of that training?
- Who was required to complete mandatory training (e.g., public or private agency employees), what topics were included, how many hours of training were required, and who, if anyone, was exempt from mandatory training (e.g., part time employees or employees with previous training or experience)?
- Who was required to obtain state certification (e.g., public or private employees), what training requirements, if any, were included (e.g., hours and topics), and who, if anyone, was exempt (e.g., part time employees, or people with previous training or experience)?

In states where either training or certification was required, the survey asked for information concerning:

- How and/or why the training requirements or certification standards were developed.
- How and by whom trainee competency was measured.
- When training was delivered to direct service workers (i.e., before starting work; during the first few days, weeks, or months; or ongoing throughout employment but after orientation.

- Whether college credit was available for direct service workers who completed training.

Training not mandated by the state was not included in the survey.

While collecting information from states, problems arose that made it difficult to obtain complete information from all of the states surveyed. Some of these difficulties included identifying informants who could provide the requested information, needing to contact multiple informants within each state in order to get complete information, reorganization efforts and changes occurring within state agencies at the time of the survey, and the lack of a common language within and across states regarding direct service workers and services (definitions of the terms *mandatory, certification,* and *direct service worker* varied widely depending upon the state and the respondent). Complete information was obtained regarding residential settings in the following 23 states: Alabama, Arizona, California, Colorado, Florida, Hawaii, Iowa, Kansas, Maine, Minnesota, Mississippi, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, Vermont, Virginia, Washington, West Virginia, and Wyoming. Ten additional states provided less complete but still valuable information.

■ Results and Discussion

It has been argued that training is important for direct service workers because it provides the worker with the opportunity to gain the knowledge, skills, and attitudes needed to perform the direct service worker role. Direct service workers with sufficient knowledge, skills, and attitudes are more likely to have a positive influence on the quality of life for the individuals receiving their services (Jones, Blunden, Coles, Evens, & Porterfield, 1981; Knowles & Landesman, 1986; Larson, Hewitt, & Lakin, 1994). Direct service positions have also become more decentralized as community services have become more broadly available. As a result, direct support workers have less supervision but need more sophisticated skills such as advocacy or bridge-building with community members. In general, states recognize the need for direct service workers to receive adequate training. As Table 2 shows, almost all of the states surveyed did mandate some type of training for residential direct service workers (16 of 17 states for public agencies, and 20 of 23 states for private agencies). However, only nine states had a certification process for direct service workers (two states for public agencies, and seven states for private agencies). States mandated training in a variety of ways: by topic, number of hours spent in training, and when the training was necessary – preservice or within a certain number of days after hire.

Of course, mandates alone do not guarantee that the direct service workers are receiving training that prepares them to meet the needs of the people they support. Mandating a new employee to have 40 hours of training does not ensure that she or he will learn anything new or relevant or will develop any skills. In recognition of this, Colorado recently dropped much of their mandated training for privately run services and moved to a more outcome-based approach that allowed private providers more flexibility in defining training requirements for each staff depending on the type of services they provided. Providers in this state reported that previous mandates forced direct service workers to be trained in some areas that were not relevant and resulted in the depletion of valuable training resources that could be used on more relevant training.

Despite its importance, there is currently little consistency in the training that direct support workers receive across the United States and within the individual states. The Community Support Skill Standards Project found that the core competencies identified for direct service workers include: participant empowerment, communication, assessment; community and service networking, facilitation of services, community living and supports, education, training and self-development, advocacy, vocational, educational and career support, crisis intervention, organizational participation, and documentation. Despite the identification of these common training needs, training requirements vary widely across service types and from state to state. This variability in training requirements is problematic for direct service workers when they attempt to move from one job to another because they are often faced with having to repeat training on topics and skills for which they are already competent. It is also costly for service agencies who have to train workers on topics for which they are already competent. Additionally, it perpetuates direct service workers feeling devalued and bored with training because long-term workers are often required to take the same training year after year or job after job regardless of experiences or skill.

When considering the development of a national credential for direct service workers it is important to recognize how and why states developed mandated training and certificate programs. One of the analyses completed for this study was an examination of events or groups which prompted the development of a certification process within states that had a mandatory certification process. A variety of reasons were cited by states as to why certification began in that particular state. In eight of nine cases, the reasons given included lawsuits, deinstitutionalization movements or state agency mandates. A variety of groups were key stakeholders in many of these movements, including service providers, professional groups, consumers/parents and advocates, and protection and advocacy organizations. Unions seemed to be the only group not reported as having contributed to the development of these mandates.

The extent to which training required by states addressed the core competencies identified within the National Skill

Table 2: Certification and Training Requirements for Direct Service Workers in Public and Private Residential Settings

State	Certification Required		Training Required	
	Public	Private	Public	Private
Alabama	No	No	Yes	Yes
Alaska	No	No		
Arizona	No	No	Yes	Yes
California		No	Yes	Yes
Colorado	Yes	No	Yes	Yes
Florida	No	No		Yes
Hawaii	No	No	Yes	Yes
Iowa	No	Yes	Yes	Yes
Kansas	No	Yes[1]		
Louisiana	No	No		
Maine	No	Yes	Yes	Yes
Massachusetts	No	No		
Minnesota	No	No	Yes	Yes
Mississippi	Yes	No	Yes	No
Montana	No	Yes		
Nebraska	No	No	Yes	Yes
Nevada	No	No		
New Hampshire	N/A	No	N/A	Yes
New Mexico		No	Yes[2]	
New York	No	No	Yes	Yes
North Carolina	No	No	No	No
North Dakota	No	Yes	Yes	Yes
Oklahoma	No	No	Yes	Yes
Pennsylvania	No	No		
Rhode Island		No[2]	Yes	Yes
South Dakota	No	No		Yes
Vermont		No		No
Virginia	No	Yes	Yes	Yes
Washington	No	No	Yes	Yes
West Virginia	No	No	Yes	Yes
Wisconsin	No	No		
Wyoming	No	No	No	No
Totals	2 of 29	7 of 32	16 of 17	20 of 23

[1] indicates Non-ICF/MR only
[2] indicates in process of implementation

Standards for Community Based Human Service Practitioners was also examined. For this analysis, state regulations provided by respondents were reviewed to determine if (a) they covered all of the skills and training topics included in each of the national skill standards competency areas; (b) they covered at least one of the skills and training topics included in the national skill standards competency areas; or (c) they did not cover any of the topics in a given national skill standard competency area.

It was rare for a state to have mandated training that covered an entire national skill standards competency area. The only exceptions were North Dakota, where the community living and supports area was covered by mandated training for private agency direct service workers, and Washington state, where the facilitation of services competency was covered by mandatory training for direct service workers in public and private agencies. State training requirements usually included some but not all of the topics and skills in a specific core competency area, and addressed some component of a competency area on an average of 4.7 of the 12 topics. The national skill standards competency areas that were most likely to be partially addressed included crisis intervention (76.2% of states), advocacy (66.7% of states), community living and supports (61.9% of states), and documentation (57.1% of states). The least common competency areas to be even partially addressed in regulations for residential direct service workers included vocational, educational and career support (4.8% of states), community and service networking (9.5% of states), education, training and self-development for workers (19.0% of states), and assessment (23.6% of states).

The specific training topics addressed in state mandates varied considerably but some common themes were evident. Many states had requirements for training on primarily medically related issues, such as medication administration, signs and symptoms of illness, cardiopulmonary resuscitation (CPR), Occupational Safety Health Administration (OSHA) standards, blood borne pathogens, and acquired immune deficiency syndrome (AIDS). In fact the only mandated training topic for direct service workers in one southern state was AIDS. Most states required direct service workers to know information about the agency in which they worked and related agency policies and procedures. Additionally, topics such as normalization, rights and interdisciplinary teams were commonly required.

Several other characteristics of mandated training were observed. One characteristic related to the national credentialing effort is the extent to which states offer mandated training for which workers could earn college credit. Of the nine states that had a certification program, only two (Iowa and North Dakota) offered college credit to direct service workers for completing the training. An even lower proportion of states provided college credits for mandatory training: three of 15 states for training mandated for public direct service workers and five of 17 states for training mandated for private agency direct service workers.

There are a variety of strategies that can be used to evaluate the effectiveness of training efforts. Those strategies range from simply asking participants if they learned something (participant opinion surveys) to actually observing trainees at their work setting to evaluate their competency in implementing training content (observation of participants at a work site). In this study, respondents were asked to indicate how competency was measured both for certification programs and for mandatory training. Among six states offering certification for direct service workers, strategies used by the largest proportion of states included written tests of

knowledge acquisition (83.3%), observation of participants in the classroom setting (66.6%), and observation of participants at their work site (50.0%). The most common strategies to evaluate the outcomes of mandated training in 17 states included written tests of knowledge acquisition (58.8% of states), observation of participants at the work site (52.9%), and performance tests (52.9%). While written tests may be helpful in gauging understanding of materials and awareness of subject matters, tests do not measure whether a direct service worker could actually perform the skill that was taught.

Several important considerations in developing a national voluntary credentialing system have already been identified, but other issues are also important. As Table 3 shows, these issues range from which work settings would be included in the training system (e.g., residential, vocational, educational, home health, recreation) to the process used to develop and implement the system, including identifying who would be involved and how each aspect will be addressed.

National voluntary credentialing has been proposed as a way to address some of these work force challenges regarding recruiting, training and retaining quality direct support personnel. National credentialing would require consensus on the part of all states as to what the credential would represent and what types of training and competency demonstration would need to occur for an individual to receive the credential. Consensus on the components of a credential is not the only hurdle. Once this has been agreed upon there must be a system for monitoring and maintaining a registry across states as to who has obtained the credential. Substantial resources would need to be identified in order to maintain such an effort.

■ Recommendations

Several key issues emerge as the training practices in the 32 states are surveyed. The following recommendations address the most important of these:

- **Require Demonstrated Competence.** Most states have some type of required training for direct service workers. However, this training is most often mandated by topic, hours, and the time frame in which training must occur. To assure that mandated training results in competence and desired levels of performance of direct service workers, mandates should require demonstrated competence of direct service workers, not simply topics and quantity of training hours. The competencies identified within the national skill standards provide one valid framework from which to build these competencies.
- **Verify Type of Training.** Since direct service workers in most states and settings must complete required training, it would be more cost-effective and efficient to develop a system for recognizing training and ability that is transportable across states and settings. This system should include a means of verifying the type of training that has been successfully completed by a direct service worker and a means for measuring their competence.
- **Incorporate Validated Standards.** Many states in this study were in the process of revising their training regulations, creating certification programs or redesigning their system of training direct service workers. Most of the topics and competencies outlined within the National Skill Standards for Community Based Human Service Practitioners are currently not included in many state's training requirements for direct service workers. Building direct service worker training programs that incorporate the validated standards will save states money by eliminating the need to complete elaborate job analyses and assist states in moving toward training that is consistent with current best practices and future trends. This would move states and service providers beyond simply meeting minimal standards or requirements regarding direct service worker training.
- **Allow Workers to Demonstrate Competency.** Most mandated training and certification programs within the states surveyed for this study focus on introductory knowledge and skills needed to work as a direct service worker in the field of developmental disabilities. Many direct service workers have worked in the field of developmental disabilities for many years and can already demonstrate competency on introductory training topics. Moving toward competency based training systems would enable workers who can demonstrate competency to "test out of" introductory and/or routine annual training requirements. This would allow training resources that were once spent on routine introductory training topics to be spent on more challenging and specialized training that is better suited to long-term direct service worker experiences and desired learning.
- **Create a Common Language.** Surveyed states clearly did not use a common language to define their direct service work force. The variety of settings in which direct service workers work (schools, group homes, supported living services, in-home, day programs, supported employment, institutions, nursing homes), the variety of titles given to direct service workers (job coaches, direct service workers, paraprofessionals, residential counselors, personal care attendants), and the many funding sources used, make it difficult to embrace a common language. However, when considering the development of any national credential or other transportable recognition of competence for direct service workers, it will be critical to know which direct service workers are included and in what kinds of settings they are prepared to work across states. Without a common language, national or

interstate efforts will struggle to obtain sufficient information to address work force development issues.

- **Consider Unique Requirements of Individual States.** Any attempt to develop a national credential for direct service workers will need to consider the unique nuances of individual state's training requirements, regulations, and certification programs. The introductory nature of most of the required training and certificate programs identified within this study suggest that the development of a more advanced credential at a national level will likely not conflict with existing state regulations and required certificate programs.
- **Give College Credit.** When possible, states should develop a means for direct service workers to gain college credit for the many hours of training they complete and the experiences gained through their work.

■ Conclusion

As the initial Community Support Skill Standard Project draws to close, and its products are tested and disseminated, the next issue for state policymakers will be to decide how to use those standards to improve the quality of the direct service work force. This *Policy Research Brief* identified some possible strategies and approaches that might be used. If a national credentialing process emerges as the logical next step, much work will remain to build a system that will indeed facilitate the delivery of high quality training that enhances the status and skills of direct service workers.

Table 3: Questions to Address in Creating a National Voluntary Credentialing System

- What types of settings will be included (e.g., residential, vocational, educational, home health, recreation)?
- Will the system apply only to public employees, private agency employees or to both? Will part-time or intermittent employees be eligible?
- Who will be involved in developing the credentialing system in each state (e.g., provider agencies, state or local governments, advocacy / parent / consumer groups, DD councils, post-secondary schools, University Affiliated Programs (UAPs), protection and advocacy agencies)?
- Will certification be required to work with consumers with particular characteristics (e.g., severe mental retardation, challenging behavior, specific medical conditions, physical disabilities, sensory disabilities)?
- Are certain workers exempt from certification requirements (e.g., those with specific college training or degrees, those certified in another state, those employed at the time the certification is instituted)?
- Who will administer the certification program (e.g., provider agencies, state or local governments, advocacy / parent / consumer groups, DD councils, post-secondary schools – including UAPs, protection and advocacy agencies)?
- Who will be responsible for assuring compliance with certification standards?
- How will compliance with certification standards be monitored?
- What role will direct service workers play in developing and monitoring the system?
- What preservice, orientation, and inservice training will be required / offered (how many hours, what topics, what curriculum)?
- Who will arrange and provide training for the certification process?
- Who will develop, distribute, and update training materials?
- What strategies will be used to measure competency?
- Will other criteria be used to gain and maintain certification (e.g., consumer satisfaction ratings, bonding, educational degrees, criminal background checks, competency demonstration)?
- Will college credit be available for direct service workers who complete training? Will that credit transfer from one type of educational setting to another? From one state to another?
- What types of field work will be included in the training (e.g., practicum, on-the-job training, apprenticeship, mentorships)?
- What experiential prerequisites will be required before certification is possible (e.g., volunteer hours, paid work experience, family member, friend)?
- Will there be any substitutes for completing required training?
- Who will pay for required training (e.g., provider organizations, direct service workers, state or local governments, DD councils, UAPs, private foundations)?
- Who will pay for curriculum development activities?

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